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HEALTH CARE NEWS

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Doctors Flee Illinois

by Steve Stanek

As the number of companies willing to sell medical malpractice insurance in Illinois shrinks and insurance premiums skyrocket, doctors are moving out of the state or quitting medicine entirely. In some counties, observers fear the medical system is on the verge of collapse.

More than 30 malpractice insurers have left Illinois or gone bankrupt over the past five years. In neighboring states such as Indiana, Missouri, and Wisconsin, malpractice insurance is readily available at one-third to one-fourth the price. Those states have imposed caps on non-economic damages, which now make up more than 90 percent of the money awarded by Illinois juries in malpractice cases.

Doctor Shortage

In key Illinois counties—including Madison, which has become infamous as perhaps the most plaintiff-friendly venue in the United States—doctors, hospitals, and some local elected officials are warning of a medical system collapse. They are taking their warning and a plea for tort reform to the most powerful voters in the state: the elderly, who are also the biggest health care consumers.

In the East St. Louis area, which includes Madison and St. Clair Counties, local doctors and retired physicians are visiting area nursing homes and retirement communities to explain the malpractice insurance situation and its impact on health care. Letter-writing and petition campaigns have collected more than 7,000 signatures in less than one month. The petitions ask state lawmakers to enact reforms to rein in frivolous lawsuits and outlandish awards to plaintiffs.

At least 60 doctors in the past two years have left or announced plans to leave Madison and St. Clair Counties. Most have cited out-of-control courts and

DOCTORS continued on page 16

"Last Chance" for TennCare

by Conrad F. Meier

In what may be the defining moment of his term in office, Governor Phil Bredesen (D) told state legislators on February 17 he would save Tennessee from the clear and present danger of unchecked TennCare spending by acting immediately to limit benefits and impose copayments on some beneficiaries.

What Bredesen called the "last chance" to overhaul TennCare is expected to stem the program's out-of-control growth, saving $2.5 billion over four years while continuing to provide services to 1.3 million Tennesseans who are poor, disabled, or otherwise not able to get insurance.

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Crane Seeks Full Tax Deduction for HSAs

by Steve Stanek

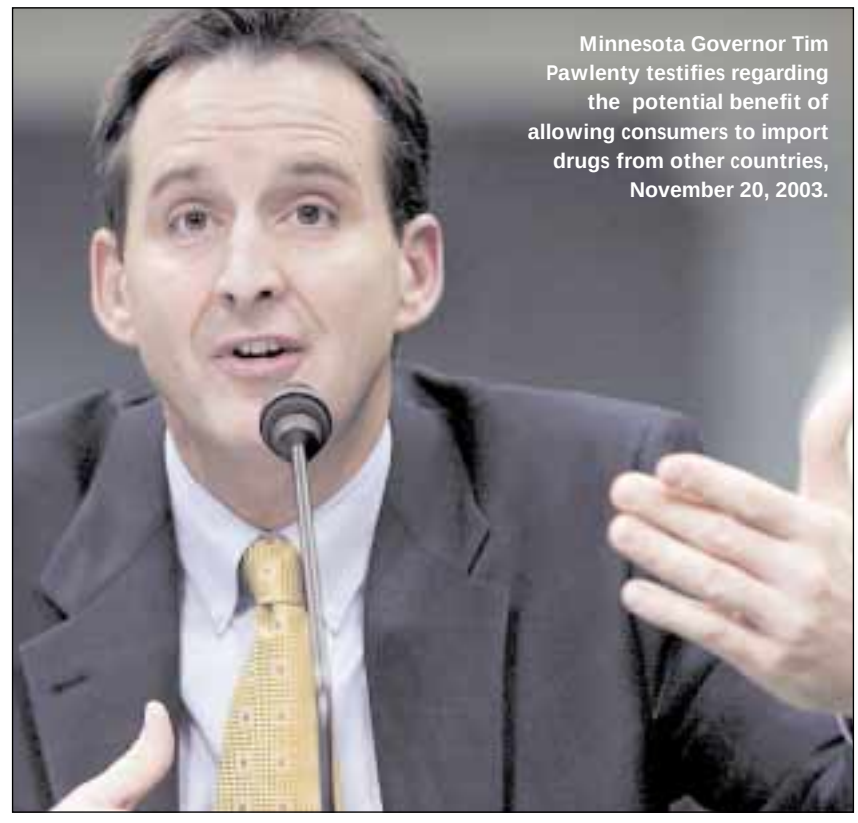
When Health Savings Accounts became law on January 1, millions of Americans received the chance to buy low-cost health insurance policies and save money in tax-free savings accounts. Now a move is afoot in Congress to make health insurance still more affordable by making HSA insurance premiums 100 percent tax-deductible.

Crane Care

"This deduction would be available to all Americans with a Health Savings Account regardless of whether the individual itemizes or not," said Congressman Phil Crane (R-Illinois), who plans to introduce tax-

CRANE continued on page 5

FDA Warns Minn. on Drug Imports



Minnesota Governor Tim Pawlenty testifies regarding the potential benefit of allowing consumers to import drugs from other countries, November 20, 2003.

KRT

by Conrad F. Meier

A strongly worded letter from the U.S. Food and Drug Administration (FDA) warned Minnesota Governor Tim Pawlenty (D) that his decision to establish a Web site offering prescription drugs from Canadian pharmacies is "unsafe, unsound and ill-considered." The letter all but orders a shutdown of the Minnesota Rx Connect Internet site, launched in January, urging Pawlenty to "reconsider [his] action."

By endorsing pharmacies "outside of our regulatory system," the letter said, "you ... shine a bright light on a path used not only by profiteers masquerading as pharmacists, but by outright criminals."

FDA Associate Commissioner Bill Hubbard, who wrote the letter, said the agency is not threatening legal action at this point. Hubbard told the *Minneapolis Star Tribune*, "We think this letter is very strongly worded and makes the point that what he [Pawlenty] is doing is unsafe. Obviously, it would be a good thing if he stopped."

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McClellan Nominated to Replace Scully

by Conrad F. Meier

President George W. Bush has nominated Food and Drug Administration (FDA) Commissioner Mark McClellan to serve as the new Centers for Medicare and Medicaid Services administrator (CMS). If McClellan is confirmed by the Senate, the job will be the third senior health policy position McClellan has held in the Bush administration.

As CMS administrator, McClellan, a physician with a doctorate in economics, would be responsible for Medicaid and Medicare, which together provide about $700 billion annually in health care benefits to an estimated 83 million people.

McClellan would succeed Tom Scully, who resigned in December and accepted a position in the Washington DC office of the Atlanta-based law firm Alston & Bird.

Tim Sloan

FDA Commissioner Mark McClellan and President George W. Bush

Challenges Ahead

According to the *New York Times*, McClellan faces "a huge logistical and political challenge" in his new role: implementing the prescription drug benefit included in the Medicare reform law while fending off Democratic attacks.

McClellan "could face sharp questioning from Democrats" over "his stated faith in the ability of private-sector companies to reduce spending and improve quality of health care," reported the *Wall Street Journal*.

While at the FDA, McClellan pushed for quicker reviews of drug and other product applications; successfully lobbied Congress to expand industry user-fee programs that fund FDA activities; and made tough decisions on controversial issues, such as banning the diet supplement ephedra and reversing an advisory panel decision to keep silicone breast implants off the market.

McClellan may be most well known for his steadfast position on the danger of reimporting drugs from Canada and other across-border sources. He has demonstrated a knack for working with members of both parties in a pragmatic way, blending economics, science, politics, and social issues.

Reaction to Nomination

Some expected McClellan to be confirmed quickly by the Senate. Observers say the nomination reflects the administration's desire to avoid a bruising confirmation battle that would give Democratic lawmakers another opportunity to tear down Medicare reform.

Senator Edward Kennedy (D-Massachusetts) called McClellan "a superb choice" to run CMS, adding, "He brings to the job a powerful intellect, a deep knowledge of the programs, and a commitment to public service."

Senate Finance Committee Chair Chuck Grassley (R-Iowa) said McClellan "is well regarded on Capitol Hill, and his background and expertise make him a strong candidate." Grassley added he would schedule the confirmation hearing as soon as possible, but gave no date.

Jonathan Skinner, a Dartmouth economist who has written articles with McClellan, said that while "McClellan has strong opinions about how to make the system better, I think he understands that in Washington you try to get done what you can get done."

"Observers say the nomination [of Mark McClellan to head CMS] reflects the administration's desire to avoid a bruising confirmation battle that would give Democratic lawmakers another opportunity to tear down Medicare reform."

Not everyone reacted so positively to the McClellan nomination, however. The *Los Angeles Times* quoted Dr. Sidney Wolfe, director of Public Citizen's Health Research Group, warning McClellan "could become 'a cheerleader for the privatization and serious weakening of Medicare because he might approach the job more as an economist than a physician.'"

McClellan's potential departure from FDA also worried some. The *Wall Street Journal* editorialized, "With McClellan's expected departure from FDA, the agency likely will once again return to bureaucratic autopilot, and to its institutional over-caution in approving even life-saving new drugs."

The editorial concluded, "We hope Mr. Bush challenges the Senate with a replacement who is every bit as aware as Dr. McClellan has been of how bureaucratic delay costs lives."

Bumpy Road Ahead

Senate Democratic Policy Committee Chairman Byron Dorgan (D-North Dakota) has threatened to hold up the McClellan nomination over a lingering dispute about prescription drug importation. McClellan has been firm in his position that importing drugs into the U.S. from other countries poses a risk to public health.

Speaking at a summit meeting of governors and members of Congress who support prescription drug importation from Canada and other countries, Dorgan said he wanted to know "what's going on over at the FDA" on the issue. According to CongressDaily, Dorgan said McClellan's nomination "is going to spend awhile" in the Senate.

If Dorgan follows through on his threat, it will be like old times for McClellan. Senator Jeff Bingaman (D-New Mexico) briefly held up McClellan's nomination to his FDA position as part of a spat between Bingaman and HHS Secretary Tommy Thompson. Thompson had withdrawn his support for a Bingaman bill that would have made pregnant women, rather than fetuses, eligible for the State Children's Health Insurance Program.

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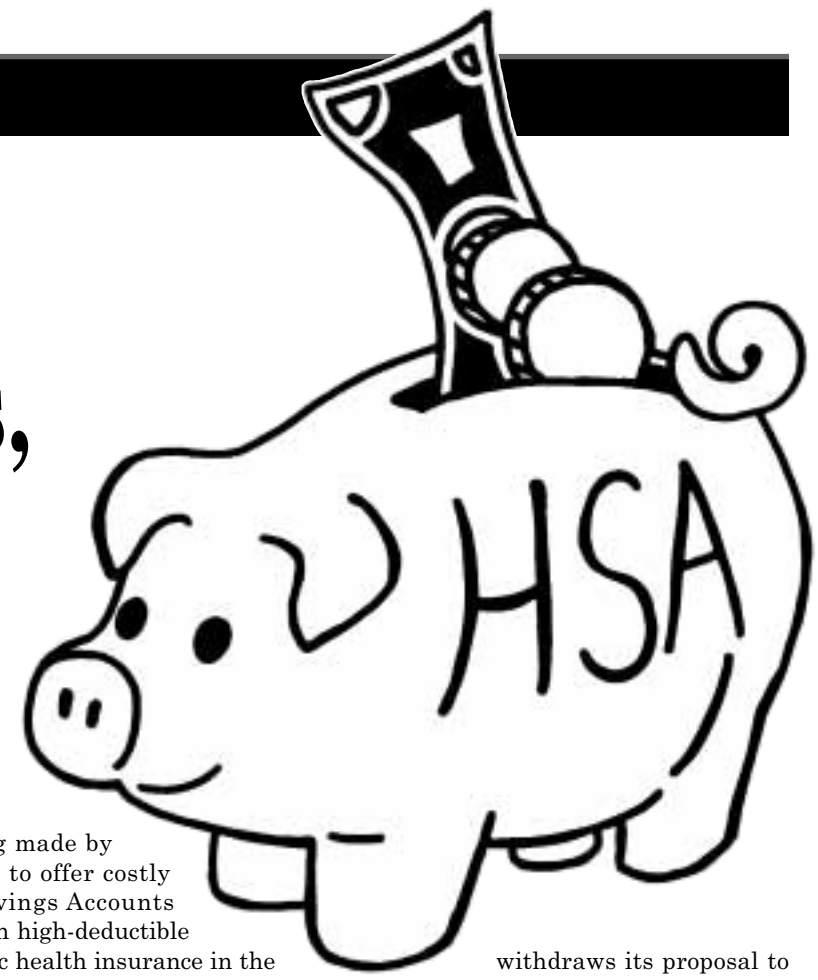
CONSUMER CHOICE **MATTERS**

Insurers Embrace HSAs, Opponents Launch Astroturf Campaign



by Greg Scandlen

Employee Benefit News reports, "with the ink barely dry on the colossus Medicare bill, [i]nsurers have already begun planning, developing, and rolling out new HSA products. Industry watchers say the HSAs are the logical evolution in the market trend toward consumer-driven health care."

The article goes on to discuss product development efforts at Aetna, Humana, and United Health Group. These will likely not be available until mid-year 2004, but Starmark "plans to offer new products that can be coupled with HSAs beginning in February (and) American Medical Security, which currently offers HSAs for individuals, will have products available by April for small employers."

The article also notes that "Fortis Health sold the first individual HSA in the country and now has products for both individuals and small groups." EBRI's Paul Fronstin adds a cautionary note, "It's probably not useful to look at 2004 as an example of whether HSAs might take off. These things don't take off in the first year, and they shouldn't be expected to."

Source: **http://www.benefitnews.com/detail.cfm?id=5579&terms=|hsa|**

In the Field

Recently a number of additional vendors have announced their own versions of consumer-driven coverage. To wit:

■ **Blue Cross Blue Shield of Minnesota** has announced an HRA-driven plan for smaller employers called "Options Blue." The plan features high deductibles, employer-funded accounts, first-dollar coverage of preventive services, and a strong on-line customer support and disease management program called Blueprint for Health. The company press release says Blueprint for Health saved the company $36 million in the first year of operation (for its regular business) and resulted in an 11 percent drop in ER visits and a 14 percent drop in hospital admissions, for a per-member claims savings of $500.

■ **Lumenos** is adding HSAs to its product line. It is well-positioned to serve this market through its wholly owned subsidiary MSAver, one of the first MSA administrators in the country. It will convert its MSA business to HSAs and continue to serve the small group market, while adding an HSA option for large employers. Company President Chip Tooke says, "HSAs broaden the appeal for consumer-driven programs by creating more flexibility and product options for employers and employees. Ultimately this empowerment will lead to better health outcomes and a more effective use of health care dollars."

■ **The Principal Financial Group** has announced a new consumer-driven product it calls the Principal Reimbursement Arrangement. It is aimed at the small to mid-sized market and features an insured HRA with consumer support services such as health assessments and case management. The news release says, "the Principal Reimbursement Arrangement is funded through premiums, allowing the employer to determine the portion paid by employees."

■ **BENU** has inked its first contracts in Oregon. It provides a "consumer-driven benefits exchange" program that offers employees a choice not only of plan design, but of carrier. In Oregon it provides both Kaiser HMO coverage and two designs from Cigna. The value BENU brings to the package is a "unique risk mechanism that eliminates carrier problems with adverse selection," according to Kaiser's Denise Honzel.

Click Here to Oppose Progress

A Congressman's office forwarded the following e-mail. This one office has received about 100 of these, supposedly from constituents, and several other offices are also being deluged. The arguments are being circulated by the National Association of Retired Federal Employees (NARFE). (See the "open letter" on pages 6-7 for a thorough rebuttal of these claims.) These folks know how to apply pressure:

"I am writing to ask you to urge Office of Personnel Management (OPM) Director Kay Coles James to withdraw plans being made by her agency to offer costly Health Savings Accounts (HSAs) with high-deductible catastrophic health insurance in the Federal Employees Health Benefits Program (FEHBP).

"I believe the proposal could further increase the premiums I pay for my comprehensive FEHBP coverage by siphoning off healthy enrollees into catastrophic/HSA plans. And, the nonpartisan Congressional Budget Office (CBO) says that legislation to make the savings accounts and high-deductible insurance available in the FEHBP would cost taxpayers nearly $1 billion over five years. Moreover, research by the nonpartisan RAND Corporation, the Urban Institute, and the American Academy of Actuaries indicates that premiums for coverage under a traditional health insurance policy could at least double if HSA use becomes widespread."

"Despite the carping of the federal unions, HSAs and HRAs are doing just fine out in the real world."

The letter goes to say, "Although HSAs may provide short-term financial gains to some individuals, their growth in the FEHBP could result in higher costs for enrollees and taxpayers in the long run. It's a mistake to transform a successful group health system—where risk-sharing keeps health insurance affordable and predictable throughout life—to an 'every man for himself' scheme—where premiums and out-of-pocket expenses are only reasonable for healthy participants.

"Some elected officials have held up the FEHBP as a model for other employers and health care systems to emulate. However, the imposition of HSAs on the FEHBP will have the opposite effect by encouraging employers to replace traditional health insurance with less-comprehensive HSAs. As a result, traditional health insurance may no longer be an affordable option for those of us in need of comprehensive coverage and our risk of losing coverage will only grow as HSAs become more dominant. For these reasons, I urge you to ensure that OPM withdraws its proposal to offer costly HSAs in FEHBP."

If you want to see what sophisticated lobbying is all about, go to the NARFE Web page, headlined "Stop New Threat to FEHBP," where you can send this letter to your members of Congress with just a click of the mouse. You don't have to be able to write or even think. All the writing and thinking has been done for you, courtesy of the union bosses.

They Don't Get it

The *New York Times* must be reading the Democrats' play book—or vice versa—because in an editorial it says the President's tax credit proposal "does not seem like nearly enough to enable people near the poverty level to buy individual policies (and the AHP proposal) is fraught with potential difficulties. But (AHPs) would clearly benefit the NFIB, a major Republican Party contributor that could reap substantial revenue selling policies." Curiously, the *Times* calls the President's ideas "a skimpy menu of warmed-over health care proposals (that) have been kicking around for years without exciting enough interest to be passed by Congress."

Actually, that is a better description of Senator Edward M. Kennedy's (D-Massachusetts) "play or pay" mandate that has been "kicking around" for at least 30 years, "without exciting enough interest" even to come to a vote in Congress.

In fact, ideas like tax credits for the low-income, premium deductibility for the middle-income, AHPs for small businesses, tort reform for physicians, and HSAs for all of us, are refreshing new approaches to solving old problems.

When it comes to "warmed over" ideas, the *New York Times* has a corner on the market.

Source: **http://query.nytimes.com**

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Crane

Continued from page 1

deduction legislation this spring. "This legislation is an important step towards reducing the rolls of the uninsured and ensuring that more people have access to affordable health care."

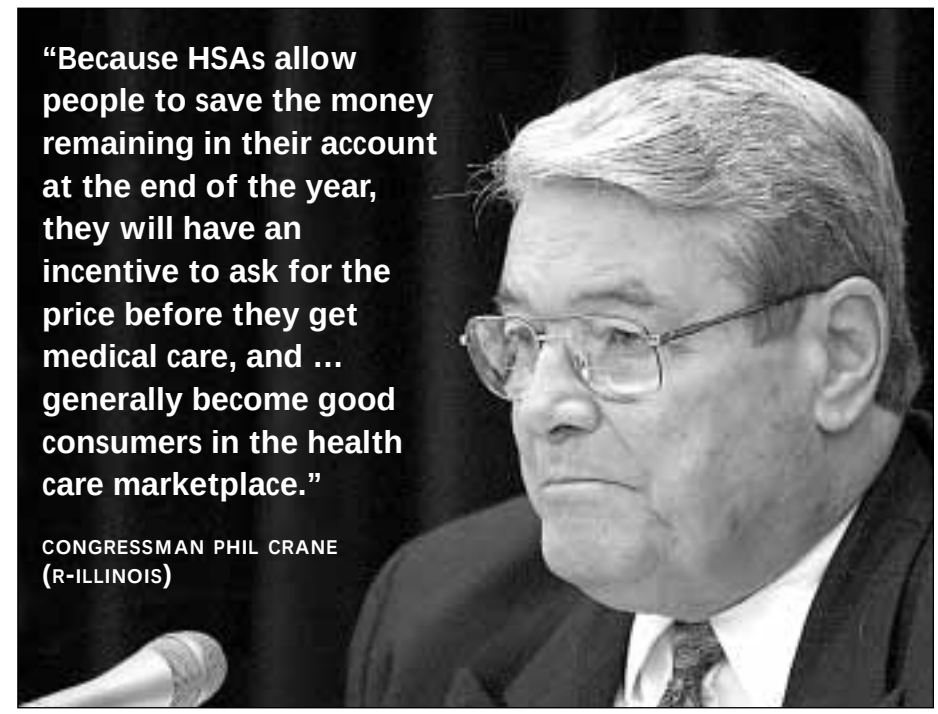
In his January State of the Union address, President George W. Bush asked Congress to pass legislation allowing individuals who buy catastrophic health care coverage as part of a Health Savings Account to deduct 100 percent of the premiums from their taxes. Under most circumstances, health insurance premiums are not deemed to be qualified medical expenses under the current HSA law. Crane said his bill would address that issue.

Congress approved HSAs late last year as part of the Medicare reform package. The HSA allows a person to buy a high-deductible health insurance policy, which can shave hundreds of dollars off monthly premiums. Eligible individuals (or their employers) may establish Health Savings Accounts to pay for routine medical expenses or expenses that would otherwise be covered by the insurance but fall within the deductible. Once the deductible is reached, the insurance coverage takes over.

If an employer establishes an HSA, employee contributions may be made on a pre-tax basis. If the employer makes a contribution to the HSA, the contribution is tax-deductible by the employer and not considered to be taxable income to the individual. The maximum pre-tax contribution allowed in 2004 is $2,600 for persons with self-only coverage and $5,150 for those with family coverage. In both cases, the contribution may not exceed the annual deductible.

The money grows tax-free and can be withdrawn tax-free for medical expenses not paid for by insurance. Funds left in the account at year-end roll over into the next year. At retirement, unused HSA funds may be withdrawn for any purpose, not just medical care, lending a financial as well as a health insurance component to the accounts.

"Because HSAs allow people to save the money remaining in their account at the end of the year, they will have an incentive to ask for the price before they get medical care, to shop around for a provider and generally become good consumers in the health care marketplace," Crane said. "Most importantly, HSAs are an essential tool to help 43 million uninsured Americans afford health insurance. People who are currently without health insurance need health coverage, and HSAs will provide an option to people who otherwise would go without medical care."


"Because HSAs allow people to save the money remaining in their account at the end of the year, they will have an incentive to ask for the price before they get medical care, and … generally become good consumers in the health care marketplace."
CONGRESSMAN PHIL CRANE (R-ILLINOIS)

Private Sector Steps Up

The Washington DC-based HSA Coalition strongly backs tax-deductibility of insurance premiums for individuals, said spokesman Dan Perrin. He said the coalition's members include several conservative policy organizations, the American Medical Association, and various business groups, including the National Federation of Independent Business (NFIB).

"We are hearing that insurers who have announced their intention to offer HSAs are being inundated with calls from consultants and large businesses that want to set up HSAs," Perrin said. "Any employer who wants to cut health care costs dramatically should be interested in getting HSA coverage. Any individual should also be interested in HSAs. And anybody who wants to show up at the gates of Medicare with cash in his pocket should be interested in the HSA."

The NFIB, which is offering HSAs through Fortis Health in Milwaukee, reported employers are saving as much as 60 percent on their medical costs.

Jessie Brairton, manager of legislative affairs at NFIB, said a recent member survey showed 90 percent of members support allowing individuals to deduct 100 percent of the HSA insurance premiums they pay.

"The support is overwhelming," she said. "We plan to write a letter of support to Congressman Crane and other lead sponsors of the legislation. This is great for individuals. For our members, it's another choice that can help them control costs."

High-deductible policies cost far less than standard policies because routine medical expenses, which make up the majority of claims, are paid for by policyholders instead of insurance companies. This reduces administrative costs and insurance payments. Most buyers of high-deductible policies do not hit their deductible in a given year, so most policyholders save significant amounts of money, Perrin said.

If a policyholder does hit the deductible, the lower premiums largely offset the higher out-of-pocket costs, he said.

"It puts health care consumers more in control of their spending," Perrin said. "You're putting money into your pocket as opposed to the pocket of an insurance company. If it irritates you to pay hundreds of dollars a month for a product you don't use much, you need to look into an HSA."

Steve Stanek is an Illinois-based freelance writer. His email address is **stanek@mc.net**.

States Wrestle with Malpractice Reform Proposals

by Conrad F. Meier

New Jersey

Physicians attending a February hearing urged the New Jersey Board of Medical Examiners to lobby state legislators to reduce the minimum level of malpractice insurance physicians are required to maintain. Doctors say reducing the mandated level of insurance will lower premiums.

According to Ruth Schulze, an OB/GYN, doctors are having to pay premiums as much as 84 percent higher than what they paid last year for the same insurance. Local hospitals have lost 20 to 35 percent of their obstetrical staff because doctors have stopped practicing or have left the state because of high insurance costs.

Last June, the Medical Society of New Jersey (MSNJ) had asked the board to reduce the required levels of malpractice coverage from $1 million per case and $3 million per year to $300,000 per case and $900,000 per year.

Dr. Mark Olesnicky, president of MSNJ, suggested the money not spent on inflated premiums could be used to hire needed staff or purchase new equipment.

The proposal, however, was criticized by lawyers, the New Jersey Hospital Association, and patients who have been victims of medical malpractice.

Connecticut

The Connecticut General Assembly Legislative Program Review and Investigations Committee held a public hearing in February on several bills to reduce malpractice insurance premiums.

The committee heard testimony regarding measures that include creating a $3 million emergency fund for doctors unable to pay their malpractice premiums; requiring physicians to take competency tests to renew licenses; creating an independent panel of doctors and lawyers to review malpractice claims before they go to court; and requiring the state Insurance Department to approve premium rate increases.

Insurance Commissioner Susan Cogswell testified she favored a cap on pain-and-suffering jury awards. She also said review panels may not be practical because of the large number of malpractice suits being filed, and that requiring insurance carriers to get approval from the Insurance Department for proposed rate increases would simply drive insurers out of the state.

Kentucky

In January, the Kentucky House of Representatives passed House Bill 450, which would create a state-sponsored company to sell malpractice insurance to health care providers; establish panels to review malpractice claims before they went to court; and require all malpractice suits to go through mediation before going to court. The bill is now in the Senate.

In February, the Senate passed Senate Bill 1, which would create a constitutional amendment enabling the General Assembly to cap damage awards in malpractice lawsuits and make other malpractice reforms. The House version of the bill has been in committee since January.

Since each chamber now has control over malpractice bills originating in the other chamber, a compromise measure may be forthcoming.

Nevada

The Nevada Board of Medical Examiners (BOME) plans to take steps to keep the public informed of its efforts on physician discipline, according to Keith Lee, an attorney for the board.

In the near future the BOME Web site will list the names of physicians disciplined by the board, along with their alleged violations. In addition, the board will send written responses to individuals who file complaints against physicians and inform them of hearings that involve their complaints.

The BOME measures are intended to address concerns raised by a review conducted recently by the Federation of State Medical Boards. While the review generally found BOME meets or exceeds its statutory responsibility to regulate the medical profession in the state, it also determined hospitals in the state do not adequately report medical errors and cited strained relations between the board and the Nevada State Medical Association, which represents physicians.

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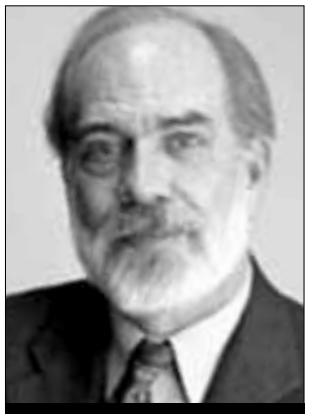
OPEN LETTER



Greg Scandlen

Opponents Misrepresent Health Savings Accounts

To: Members of Congress
From: Greg Scandlen
Subject: Recent Attacks on HSAs

You have received emails from certain interest groups urging you to oppose adding Health Savings Accounts to the Federal Employees Health Benefits Program.

You have been told that traditional FEHBP premiums could double because HSAs would siphon off healthy enrollees from the comprehensive plans. These letters cite a number of old studies to support their claim, including ones by the RAND Corporation, Urban Institute, American Academy of Actuaries (AAA), and a Congressional Budget Office (CBO) estimate that adding MSAs to the FEHBP would cost $1 billion over five years.

It is important to understand what these studies actually say, rather than just accepting the spin that has been put on them. Of these, the AAA study is perhaps the most important. That was the basis of the CBO estimate, though the CBO study had other flaws as well.

American Academy of Actuaries

The AAA study was a serious piece of work performed by a working group of respected actuaries with varying points of view. It is a gross distortion to characterize it as anti-MSA or suggest it predicted massive selection problems with MSAs. The study was written in 1994-1995, and published in May 1995—well over a year before the HIPAA MSA provisions were even written, and certainly years before there was any experience with the approach.

The study was necessarily speculative. It could not focus on the specific designs that would become law, including how the programs would be treated for tax purposes. The authors didn't know who would be allowed to contribute to the MSA or how much they could contribute. They didn't know what sort of insurance coverage would accompany the MSA.

The study is full of cautions about program design. It says if employers pay a percentage of health plan costs, "a destructive cost spiral can result for the richest benefit option. However, multiple-option programs can be designed so as to avoid the spiral, by maintaining the same relative level of employee contributions among the various options from year to year."

More importantly, the AAA did not know and could only guess at how consumer behavior would change. The authors knew that higher cost-sharing results in lower utilization, but they did not know how the presence of an MSA would change that dynamic. Would employees view the money in the MSA as their own money and therefore spend it wisely, or would they view the funds as the employer's money and spend it without constraint? "Appreciating this distinction is critical to determining the precise effects of MSAs on utilization," the study says.

"We now know that the people with the greatest health care needs are the very people who want the most control over their own health care decisions. They find consumer-driven health care, including MSAs and HSAs, very attractive for that reason."

The environment in 1994-95 was unique. The "backlash" against managed care had not yet set in, and the assumption was that HMOs would continue to be the dominant form of coverage. The study cautions, "Integrating the MSA concept with current managed care approaches, such as HMOs, will be difficult. Adoption of MSAs would require major changes, such as modifying state and federal HMO laws."

Few analysts could foresee at the time that the consumers who were most discontented with managed care would be the highest utilizers. It was assumed that sick people would be concerned solely with out-of-pocket costs, not with gaining access to the physicians and treatment programs they preferred. We now know that the people with the greatest health care needs are the very people who want the most control over their own health care decisions. They find consumer-driven health care, including MSAs and HSAs, very attractive for that reason.

Congressional Budget Office

CBO estimated in 1998 that adding a HIPAA-qualified MSA to the FEHBP "would raise mandatory federal outlays by $0.4 billion over [a five-year period, and], subject to appropriations action, discretionary spending would increase by $0.5 billion." How did they derive that? "CBO assumes enrollees selecting the catastrophic/MSA option would tend to be better health risks than those remaining in comprehensive plans."

Not just better risks, but their costs would be 33 percent lower than the comprehensive plan premium. CBO also figures some of the 10 percent of federal employees who currently decline coverage would find the MSA attractive enough to enroll for the first time—not precisely a bad outcome.

CBO cites the experience of the government of Ada County, Idaho, which, though CBO doesn't mention it, was not eligible for HIPAA-qualified MSAs and had no federal tax advantage. Ada County's decision to stop offering MSAs was mostly tied up in local politics rather than a reflection of actual experience. CBO also cites the AAA study mentioned above and concedes its "estimates of selection results are uncertain." One might think that with uncertain estimates an agency would offer a range of possibilities, but that isn't how CBO works. It is required to come up with a specific number, regardless of the uncertainties.

Urban Institute

The Urban Institute released a study in April 1996 that tried to estimate the "winners and losers" with widespread adoption of MSAs. Again, the study predates the enactment of HIPAA so it is fairly speculative. But it doesn't deal with selection at all, basing its estimates on universal adoption of MSAs. It concluded that 75 percent to 80 percent of the population would gain from MSAs, including low-wage workers. The people who would be financially disadvantaged would be those with annual expenditures in the range of $2,000 to $5,250. People with higher costs would find it a wash.

It is an important finding because people with mid-range expenditures are precisely where the greatest opportunity for cost-containment lies. Healthy people don't consume enough health care services to make much of a difference, and the very high utilizers are unable to influence their own consumption very effectively. It is in the middle range, where people use significant services and also are likely to be well enough to change their buying patterns, that MSAs are most effective.

RAND Corporation

The opponents of HSAs cite some unidentified RAND study, but most of RAND's work has been very favorable to HSAs. RAND has produced a number of important studies, starting with the landmark Health Insurance Experiment published in the early 1980s. (The study was conducted in the 1970s.) This study is actually the basis for most of the MSA/HSA activity. It showed definitively that people will consume more health care services when care is free, and far less when there is significant cost-sharing—without adverse effects to their health condition.

The most germane RAND study was "Simulating the Impact of Medical Savings Accounts on Small Business," conducted by Dana Goldman, Joan Buchanan, and Emmett Keeler. This study found MSAs attracted the *least* healthy population by far, while the wealthiest people preferred HMO coverage, not MSAs.

The same RAND research team conducted an earlier study that was published in the *Journal of the American Medical Association* (JAMA) in 1996.

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They found, "Depending on the size of the catastrophic limit, waste from the excessive use of generously insured care could be reduced, and MSAs would be attractive to both healthy and sick people."

Better Information Is Available

It is not necessary to base policy on nine-year-old speculations, projections, estimates, and simulations. Today we have real-life experience upon which decisions can be based.

MSAs have been in business for seven years, and there is absolutely no evidence they have had selection problems. Enrollment has been low because of the restrictions placed on them under HIPAA, but the hysterical predictions from some quarters—"MSAs will destroy the insurance pool," "MSAs have become the Trojan horse that could destroy health insurance reform. [They] will raise premiums for the vast majority of Americans"—have clearly not materialized.

What we have seen is that MSAs appeal to a segment of the population that has declined any other kind of available coverage. The IRS reports 73 percent of MSA buyers had been previously uninsured.

More significantly, we now have nearly two years of experience with Health Reimbursement Arrangements (HRAs). The Galen Institute brought six of the leading vendors to Capitol Hill on February 11, 2004, to discuss their experience.

They report that, when given a choice, the people who choose HRAs actually tend to be older and slightly sicker than those who do not. But they also tend to make much better use of preventive services, use generic drugs much more, use hospital ERs much less, access supportive services like nurse hotlines much more, and generally have been holding down costs significantly. This material is all available at the Galen Web site at **http://www.galen.org**.

Now Health Savings Accounts are available as a new option. There hasn't been any reportable experience with them yet since they have been in effect only since January 1 of this year.

But HSAs solve many of the design issues the actuaries were concerned with, such as allowing first-dollar coverage for preventative services and lower allowable deductibles. Most importantly, they address the AAA question of whether employees will think of the HSA money as their own to be spent wisely.

HSAs belong to the worker, and they allow both employer and employee to contribute. Balances roll over from year to year and are fully portable when a worker changes jobs. There is no question workers will see this money as their own. And the opportunity to save a little money for future needs is of far greater value to lower-income workers than to "the wealthy." Saving $1,000 a year means a lot to someone making $25,000, but not so much to someone making $100,000.

Employers all over the country—big companies, small companies, and everything in between—are setting up HSA programs for their workers. It would be a shame if the federal government deprived its workers of the opportunity to take advantage of this bright new idea by basing its decision on outdated or irrelevant studies.

"It is in the middle range, where people use significant services and also are likely to be well enough to change their buying patterns, that MSAs are most effective."

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *For more information, please contact him at* **gmscan@aol.com**, *phone 301/606-7364.*

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Free-Market Crisis and Opportunity

by Jane M. Orient, MD

"Once millions of HSAs are established, it will be almost impossible to reverse this program," writes Physicians for a National Health Program (PNHP) on its Web site (**http://www.pnhp.org**); thus, it calls for an immediate repeal of the Health Savings Accounts enabled in the Medicare Prescription Drug, Improvement, and Modernization Act.

Editorialists called HSAs "Teddy's nightmare" (*Wall Street Journal*, 12/23/03) because a reinvigorated private medical insurance market could end the dream of Senators Kennedy, Clinton, et al. for Canadian-style socialized medicine.

The IRS has issued rules (available at **http://www.irs.gov/pub/irs-drop/n-04-2.pdf**), and Aetna, Fortis, and other insurers are writing policies. About 30 percent of employers are expected to start offering such plans, according to Helen Darling of the Washington Business Group on Health.

To be eligible, a person must have a qualifying high-deductible health plan (HDHP) and may not have coverage (even as a spouse or dependent)under a plan that is not an HDHP. An HDHP has an annual deductible of at least $1,000 and maximum annual out-of-pocket expenses of $5,000 for an individual or $2,000 and $10,000, respectively, for a family.

HSA trustees or custodians are not required by the IRS to determine whether an HSA distribution is used for qualified medical expenses. Individuals need to keep such records in the event of a tax audit. There is a 10 percent penalty on top of taxes for using the funds for non-qualified purposes, except after a beneficiary's death, disability, or attainment of age 65.

As PNHP points out, the tax advantages are not great, especially for those who don't pay taxes. The tax benefit ranges from $200 for a person with an adjusted gross income of $35,000 to $721 for a person with an AGI of $500,000 or greater (*Wall Street Journal*, 12/23/03). It's the insurance premium saving that is, over time, supposed to fund the deductible.

Many will probably choose, as PNHP fears, to use their HSA as a form of individual retirement account (IRA). If a head of household contributes 100 percent of a $4,000 deductible each year starting at age 30, and withdraws $1,000 per year to pay medical expenses, a nest egg of $284,509 would accumulate in 35 years, assuming a 5 percent rate of return, according to a chart distributed by the Archer MSA Coalition.

This individual benefit, PNHP laments, would come at the expense of "fragmenting the health care risk pool." If healthier subscribers withdraw from "comprehensive" plans, the cost of such coverage "may become so exorbitant that it doesn't exist for you—or your employer may not be able to afford it," stated Edwin Park of the Center on Budget and Policy Priorities. (*Wall Street Journal*, 12/23/03)

At present, there is no common risk pool, observes Greg Scandlen of the Galen Institute, but rather tens of thousands of little risk pools. Moreover, the cost of comprehensive coverage is already so high that more employers and workers are doing without insurance altogether.

What PNHP has in mind, of course, is to create a giant risk pool with national health insurance. However, "there is no pooling when government pays," writes Linda Gorman of the Independence Institute. "Government payment is an entitlement, not insurance. Raw political power decides what government will spend on health care and who it is going to spend it on. Government has no contractual obligation to ... allow you access to medical care. In the Netherlands, it simply encourages physicians to murder citizens judged to be consuming too many medical resources.

"Private insurance companies, on the other hand, have contractual obligations, and it is one of the wonders of the market system that they generally meet them."

Reliance on force vs. trust in voluntary contracts is the key difference between "social insurance" (compulsory income redistribution) and true insurance. The new plans based on consumer choice are "another nail in the coffin of health insurance as a form of social insurance," writes Victor Fuchs of Stanford University. He expects national health insurance to come to the U.S. in the wake of war, depression, or large-scale civil unrest (*New England Journal of Medicine* 2002; 246:1822-1824).

There may be only a narrow window of opportunity to avert a crisis in the affordability and availability of medical care, leading to cries for a government takeover from desperate patients and doctors trapped in the system. "Our society has been infected with a cancer called socialism," writes Joseph Lee Pugh. "If it isn't stopped this time, it won't be stopped again."

Talented physicians are opting out of third-party payment. Customers are demanding lower prices. The American Hospital Association is demanding a safe harbor from the Anti-Kickback Statute for giving uninsured patients a discount. Nonprofit hospitals are opening cash-based clinics. Prices are being posted on the Internet.

"The Health Care Rebellion" is well underway, writes Pugh. It could be, in Chruchill's words, "the end of the beginning," if not the beginning of the end.

Jane M. Orient, MD is executive director of the Association of American Physicians and Surgeons. A longer version of this essay first appeared in the February 2004 issue of the group's newsletter, AAPS News.

TED KENNEDY

INTERNET INFO

For more information visit the Web site of the Association of American Physicians and Surgeons at **http://www.aapsonline.org**, or write AAPS, 1601 North Tucson Boulevard #9, Tucson, AZ 85716.

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Throughout the United States, physicians are being threatened, impoverished, de-licensed, and imprisoned for prescribing in good faith with the intention of relieving pain.

The "War on Drugs" has come to mean a war on lawful drugs – and against the doctors who prescribe them and the patients who take them.

Prosecutors make careers out of high-publicity cases involving the hot drug du jour such as OxyContin.

But this war is causing enormous collateral damage and deaths from friendly fire.

Physicians have been drummed out of practice, sent to jail, and even been driven to suicide in the face of these 21st century witch hunts.

If this continues, not one doctor will be willing to prescribe the drugs that patients so desperately need

The real problem is not drugs, but drug *misuse*.

"PROJECT: COMMUNICATE AND COOPERATE"

AAPS 3-POINT PLAN TO STOP THE DRUG WAR ON PHYSICIANS & REDUCE Rx DRUG ABUSE

Tucson physician Jeri Hassman, M.D., and the AAPS have developed the 3-point *"Communicate and Cooperate"* campaign to encourage physicians and law enforcement to work together to prevent prescription drug abuse.

- Work together to track and report potential drug abusers.
- Joint reviews of potential cases before charges are filed.
- Mutual training to advise law enforcement of current trends and cutting edge treatments.

Every physician who holds a DEA license should be on alert.

Details of *Project: Communicate and Cooperate* are posted on the AAPS website.

Also, be sure to read *Advice to Physicians Re: Pain Management.*

What you can do:

1. Report problems to AAPS

2. Write Members of Congress (Sample letter online)

Join the march on Washington...
"Americans In Pain"
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(see website for details)

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THIRD IN A SERIES

NEW YORK HEALTH INSURANCE: "Consumers Are Outraged"

by Conrad F. Meier

In the early 1990s, Empire Blue Cross Blue Shield (BCBS) in New York was the largest private not-for-profit insurer in the nation. But its financial statements showed a company in serious trouble. It had violated state insurance regulations and pressed for enormous premium increases on individual policy holders, while at the same time selling health insurance polices below cost to major corporations and large employer groups.

Elizabeth McCaughey, Republican candidate for lieutenant governor at the time, described the situation in a September 1994 essay for the *Wall Street Journal*. "The financial statements [for Empire Blue Cross and Blue Shield] complete a distressing picture drawn by the U.S. Senate Permanent Subcommittee on Investigations last year. Federal investigators concluded that Empire BCBS lacked the ability to 'properly execute the most basic functions of an insurance company.'"

As insurer of last resort for New York residents, BCBS sold community rated, guaranteed issue policies at state-regulated prices in exchange for an exemption from state and local income taxes. It was allowed to pay hospitals lower prices for services than other commercial health insurers in the market were allowed to pay.

In Need of a Bailout

As premiums increased and financial problems continued to mount, it became clear BCBS needed some kind of bailout. When a for-profit company is poorly managed, the stockholders are the losers. When a non-profit insurer is badly managed, it is the policyholders who get hurt.

Telling the state legislature it was about to lose more than $438 million from combined underwriting losses in 1991 and 1992, BCBS lobbied for a whopping rate increase. The insurance commission approved an increase of 25.5 percent.

The situation made legislators think further reforms were needed to control the entire health insurance market and protect BCBS from further losses. In 1993, they imposed community rating and guaranteed issue mandates on the state's individual and small group insurance markets. According to a *New York Times* report dated April 2, 1993, "BCBS maintained the new laws applying to private insurers would make the entire market more competitive."

The state's intervention in the insurance market affects not only insurance carriers and policyholders, but brokers and insurance agents as well. Insurance professionals are forbidden from selling or servicing individual health insurance policies in New York, even if the professionals are state-licensed and represent state-licensed health insurance companies that offer legitimate insurance policies. New Yorkers must purchase directly from an HMO or Healthy New York, the government-run insurance program.

Explained Patti Goldfarb, past president of the New York State chapter of the National Association of Health Underwriters, "If you are self-employed or you're an individual whose employer does not offer health insurance, your insurance options have been severely limited. There is no professional insurance support; your ability to research the available insurance companies is limited, and the ability to have someone advocate for you when claims are denied is greatly curtailed. This [fighting denial of claims] is a difficult undertaking for most individuals."

Premium Increases

"The New York version does not have a high-risk pool, does not allow age weighting, and disallows any medical underwriting," Goldfarb said. "Everyone has to be accepted at the same rate—healthy or not."

Mickey Lyons, downstate president of NAHU and Goldfarb's partner at Medical Link, Inc. New York City, added, "The impact on health insurance premiums was enormous. Insurance underwriters recognized that the law now required them to assume greater unknown risks and were forced to increase premiums accordingly and significantly."

One month after the community rating and guaranteed issue mandates went into effect, nearly 10 percent of the state's insured population experienced premium increases ranging from 20 to 59 percent. Rates for a 30-year-old single male increased by 170 percent. By July 2003, individual and family policy rates were higher still. (See Figure 1.)

"One month after the community rating and guaranteed issue mandates went into effect, nearly 10 percent of the state's insured population experienced premium increases ranging from 20 to 59 percent."

"We are astounded," Senator Guy Velella (R-Bronx), a lead sponsor of the mandate bill, told the *New York Daily News* on March 10, 1993. "I don't know of one legislator who was prepared for the size of these [premium] increases. Consumers are outraged."

Toby McAfee, from Yonkers, was one of those outraged consumers. He wrote to the *New York Times* in August 1993, "My wife and I eat carefully, do not smoke, and exercise regularly. Are we paying health insurance premiums based on the poor health habits of others under the New York State law that mandates community rating rather than experience rating?"

In an answer that rings of Orwellian newspeak, John Calagna, a spokesman for the Department of Insurance, responded, "When it comes to health insurance, there are only two types of risks—poor risks and those that will become poor risks. It's a fact of life that as we grow older, our need for medical services intensifies."

Comparing Rates

A study released in September 2002 by the online health insurance brokerage ehealthinsurance puts New York's insurance rates into perspective. The study compared the cost of 20,000 policies, with 7,000 different benefit "mixes," issued in 42 states by more than 70 insurers, including large group plans offered by BCBS.

In California, which imposes neither community rating nor guaranteed issue on individual health insurance, the average holder of an individual policy paid an annual premium of $1,538. In Pennsylvania, the premium would be $1,236; in Texas, $1,397; and in Florida, $1,821. But in New York, ehealthinsurance reports that person would have paid $3,589 for similar benefits.

Data compiled by the Medical Expenditure Panel Survey (MEPS), a project of the Agency for Healthcare Research and Quality, finds New York to be the second most-expensive state in the country (behind Massachusetts) for family insurance offered in the small group market. At an average annual premium of $8,427.50, such insurance in New York is 42 percent more expensive than in California and 48 percent more expensive than South Dakota, the least-cost state. (See Figure 2.)

The Mutual Experience

Before community rating and guaranteed issue, Mutual of Omaha, one of the largest providers of individual indemnity health insurance policies in the state and the last to exit the market, charged a 25-year-old male on Long Island $81.64 a month. By contrast, a 55-year-old Long Islander buying the same policy paid $179.60.

Almost immediately after the mandates were passed, both residents paid a monthly premium of $135.95—a 67 percent increase for the 25-year-old and a 25 per-

Guaranteed Issue

Guaranteed issue (GI) laws forbid health insurance companies from denying coverage to anyone who applies for health insurance, including those individuals who apply for insurance after the onset of a chronic health condition or who have made lifestyle choices known to be unhealthy. Adopted to help end "job lock," GI has the unintended consequence of encouraging people to wait until they get sick before buying health insurance, which increases the number of uninsured and the premium costs for those who remain insured.

Community Rating

Pure community rating (CR) laws require health insurance companies to charge the same premium to everyone, regardless of age, sex, health history, lifestyle choices, and regional demographics. This one-size-fits-all rate results in charging young and healthy people higher premiums than their expected medical expenses would otherwise justify in order to subsidize rates for middle-aged, older, and less-healthy people.

Under "modified" CR, premium variations are allowed to compensate for certain risk characteristics such as age, sex, and family size, but not for others such as health status or lifestyle choices.

— C.M.

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cent decrease for the 55-year-old. The older policyholder's gain at the expense of the younger was short lived: By 1994, declining participating by younger people in the individual insurance market caused monthly premiums for both males to reach $183.79. The 55-year-old was now paying more than he had before community rating and guaranteed issue.

By 1997, the monthly premium had risen to $217.59. Even more people dropped their individual health insurance polices, and many were forced to rely on charity health care, state government-run health plans, and Medicaid.

More Uninsured

The New York Department of Insurance reported 43,666 individual policyholders canceled their insurance within 12 months of the mandates' effective date. The share of the state's population that was uninsured jumped from 20.9 percent in 1990 to 24.8 percent in 1995. The national average in 1995 was just 17.4 percent.

According to the actuarial firm Milliman and Robertson, Inc., the mandates caused policy cancellations on a much greater scale than the Department of Insurance acknowledged. Milliman estimated 500,000 New Yorkers with individual and small group health insurance canceled their policies, reducing the number of insured from 2.8 million to 2.3 million. One out of every six New Yorkers covered by individual or small group policies became uninsured as a result of the community rating and guaranteed issue mandates.

In 1994 Mutual of Omaha reported it insured nearly 90,000 New Yorkers through individual plans in 1993. Fifteen months later, 43 percent of those policies had lapsed. All private insurance companies doing business in New York at the time had similar experiences.

More than half of those who dropped their policies, reported Mutual of Omaha, were under 35 years of age. The average age of those who renewed was 45. Forty-three percent of those who dropped a policy did not replace it with other coverage, becoming one more statistic in the state's uninsured population.

Between 1992 and 1993, Mutual of Omaha's claims cost doubled in New York. Nationally, the company's claims cost increased just 12 percent over that same period. Dr. John C. Goodman, president of the National Center for Policy Analysis, explains, "As the younger, healthier generation drops out of the health insurance rating pool, the remaining insured are older, sicker, and more expensive."

More than 20 commercial indemnity companies, including Mutual of Omaha, either left New York entirely or stopped writing health insurance policies between 1993 and 2000. Competition in the industry became almost non-existent, leading to continued double-digit premium inflation among the few carriers that remained.

According to U.S. Census Bureau figures, 11.5 percent of New York residents were insured in the individual market in 1992. By 2001, that share had fallen to just 5.6 percent. By comparison, in the U.S. roughly 12.7 percent of the population had individual coverage in 1992, falling to 8.3 percent by 2001.

"One out of every six New Yorkers covered by individual or small group policies became uninsured as a result of the community rating and guaranteed issue mandates."

Burden Shifts to Taxpayers

Health insurance reformers refused to admit, even after they were warned by policy experts, that the situation they faced was due primarily to the mandates they had passed earlier, with only a small part attributable to normal health care price inflation.

In 2000, alarmed by the high number of uninsured people in the state, now 3 million, the state legislature created a state-run health insurance bureaucracy called Healthy New York (HNY). Instead of repealing the mandates responsible for the situation, HNY would insure the uninsured at artificially low premiums subsidized by taxpayers. Between January 2001 and July 2003, HNY benefitted from taxpayer subsidies totaling $130 million.

To qualify for coverage under HNY, an applicant must have an annual income at or below 250 percent of the federal poverty line—about $50,000 for a family of four; must have been uninsured for the previous 12 months; and must not be eligible for private group insurance, Medicare, or Medicaid. New Yorkers covered by HNY pay premiums that are 50 percent of the market rate; taxpayers make up the difference.

The state was divided into nine geographical regions, with HNY being the primary, government-run subsidized health insurance option in all nine regions. The number of participating HMOs varies from three in Buffalo to 13 in the Long Island region. Different HMOs operate in different regions.

Premiums paid by those insured under HNY are community rated, although geographical variances are permitted. Annual rate increases up to 10 percent are permitted without approval from the Department of Insurance. Policies are subject to the guaranteed issue mandate, but the provider can impose a pre-existing condition limitation based on treatment or advice given up to six months before the policy's effective date.

"Finger in the Dike"

While efforts to restore the free market for individual and small group insurance have been slow in coming, a step in the right direction was taken during the 2002 legislative session.

In an effort to make health insurance more affordable for the individual sole proprietor, the state legislature passed and the governor signed Senator James Seward's (R-Otsego County) bill that redefined "small group." Before the measure passed, "small group" meant a group of 2 to 50 employees. With Seward's measure, "small group" now means 1 to 50 employees.

The distinction is of great importance to small businesses. According to Elliott Shaw, director of government affairs for The Business Council of New York State, Inc., "This legislation allowed sole proprietors to continue to purchase individual health insurance [at small group rates]. Failure to pass this measure would have meant sole proprietors would have been forced to either pay the inflated individual premium, go uninsured, or turn to government programs."

Shaw also told *Health Care News* that the legislation, while beneficial, was only a "finger in the dike."

"During the current 2003-2004 premium rate cycle, small employer groups have experienced a 30 percent premium increase," he noted. Shaw further explained the smallest groups, particularly those with 1 to 7 employees, adjusted to the cost by letting one employee go in order to afford health insurance for the remaining six.

Sun Rises on the HSA

Shaw told *Health Care News* that Seward was expected to introduce a bill in the current legislative session to formally recognize Health Savings Accounts (HSAs) as a legitimate consumer option in the New York market. By allowing consumers to purchase higher-deductible individual insurance plans, HSAs allow consumers to avoid some of the inflationary consequences of community rating and guaranteed issue. If Seward's measure passes, New Yorkers would find their HSA premiums significantly lower than what they currently can buy.

The New York legislature should also consider the establishment of a workable high-risk pool in the state, which would address the needs of the medically uninsured and uninsurable without skewing the insurance market for everyone else. The federal government has made available $1 million in seed money for states to launch such pools, and New York policymakers ought to accept that offer.

Mandated insurance benefits, which needlessly raise the price of insurance, should also be rolled back, and the legislature should consider—as other states have done, and as President George W. Bush has proposed—giving individuals who buy insurance the same tax breaks as those whose employers provide insurance.

Next month: Kentucky

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

Figure 1: Average Annual Insurance Premiums in New York

	March 1993 Before Community Rating	April 1993 After Community Rating	July 2003
Single Male Age 30	$1,200	$3,240	$4,152
Single Female Age 30	$1,800	$3,240	$4,152
Family Age 30	$4,020	$7,680	$11,008
Single Male Age 45	$2,520	$3,240	$4,152
Single Female Age 45	$2,640	$3,240	$4,152
Family Age 45	$6,300	$7,680	$11,008
Single Male Age 60	$5,800	$3,240	$4,152
Single Female Age 60	$4,380	$3,240	$4,152
Family Age 60	$11,640	$7,680	$11,008

Source: March and April 1993 figures compiled in April 1993 by Conrad F. Meier from data supplied by New York State Department of Insurance.

July 2003 figures represent an average of the lowest HMO premium offered in each of the nine regions established by the state for health care insurance purposes. Complete rate breakdowns are available at http://www.nyshmoguide.org/guides/2003GuideToHealthInsurers.pdf.

Figure 2: Average Annual Insurance Premiums Family Coverage through Small Groups

Highest Average Annual Premiums		Lowest Average Annual Premiums	
Massachusetts	$8,468.86	South Carolina	$6,083.00
New York	$8,427.50	Kansas	$6,041.64
New Hampshire	$8,290.90	Virginia	$6,009.21
New Jersey	$8,274.53	Iowa	$5,989.04
Connecticut	$7,597.89	California	$5,945.61
Maryland	$7,268.98	Mississippi	$5,901.51
Florida	$7,206.48	Kentucky	$5,894.18
Wisconsin	$7,134.04	Missouri	$5,790.45
Pennsylvania	$7,123.71	North Dakota	$5,713.15
Texas	$7,047.92	South Dakota	$5,678.65

Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, 2000. http://www.meps.ahrq.gov

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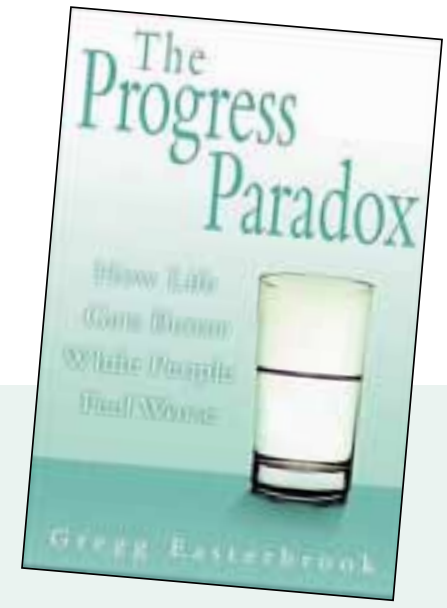
BOOK **REVIEW**

Happiness and Health in a Prosperous Society



The Progress Paradox:
How Life Gets Better While People Feel Worse

by Gregg Easterbrook
(Random House Publishers, 2003;
376 pages, $24.95, ISBN: 0679463038)

by Jay Lehr, Ph.D.

Between the media's emphasis on crises and grievances, and the fears engendered by 9/11, it is common to hear that things are going to hell, that our parents had it better. But objectively, almost everyone in today's United States or European Union lives better than his or her parents did.

Nevertheless, studies show the percentage of the population that is happy has not increased in 50 years, while depression and stress have become more prevalent. Gregg Easterbrook's *The Progress Paradox* explores why ever-improving living standards don't seem to make us any happier. Detailing the emerging science of "positive psychology," which seeks to understand what causes a person's sense of well-being, Easterbrook offers an alternative to our culture of crisis and complaint.

Our Genetic Predispositions

Easterbrook explains, using the language of the nature versus nurture debate, the origins of humankind's least-desirable traits, including lack of appreciation, vanity, and conspicuous consumption. These traits, among others, make us bear much of the blame for the fact that while life by any measure has gotten considerably better over the last 50 years, the percentage of people who consider themselves happy has not risen a single percentage point over the 50 percent figure tallied in 1950.

From buying watches, washing machines, houses, and cars for the primary purpose of burning money and keeping up with the Joneses [which Easterbrook refers to as "call and raise the Joneses"], he recounts the absurdity of so much we do—from our personal paper shredders ("must not let our important paper fall into the hands of a shrewd trash collector") to devices that alert us to incoming calls while we are surfing the Web.

On a more serious note, Easterbrook expresses our ignorance toward the destructiveness of excess weight. "Today an estimated 280,000 Americans die prematurely of obesity and its complications each year; the second-worst preventable cause of death after lung cancer from smoking, and dozens of times more than the worst-case fatalities toll from environmental exposure to toxins and similar issues over which Americans obsess. ... Today citizens of the United States live in a society that lionizes the one person in a thousand who can run a marathon but otherwise seems devoted to eliminating physical activity altogether."

Stress and Health

The Progress Paradox summarizes the outpouring of medical studies on the impact of stress on today's human condition. The evidence for stress creating a long list of serious disorders is clear and incontrovertible, but he is also confident it has led to a massive exaggeration of illness because of the ease offered in laying the blame for any personal problem at the feet of a medical disability.

Easterbrook makes a strong case for what many of us believe—namely, that while children with Attention Deficit Disorder can benefit greatly from Ritalin, and adults who are clinically depressed can benefit from Prozac, the overuse of these drugs is masking … and indeed, likely causing … many other problems.

"Easterbrook makes a compelling case that optimism, gratitude, and acts of forgiveness not only make modern life more fulfilling but are actually in our self-interest."

With significant medical support Easterbrook lays part of the blame for public malaise, even in the face of the good life we now live, on the facts that we grow steadily overweight, sleeping fewer hours and less soundly, producing ever-more cortisol, the stress-inducing chemical in our bodies. It is likely we would experience less stress and anxiety if we ate less, did a half-hour of exercise every day, and read a book before bed instead of watching television. But, he writes, and most will agree, "this requires a change of lifestyle, while most people want an Rx instead."

At the same time, Easterbrook recognizes the frivolity of thinking we can ever return to a much less stressful way of life. We will never get away from the technology that stresses us, he notes, because it becomes ever safer and more benign. He makes it clear that left-leaning anti-technology "greens" are losing out when he points out that despite endless money anxiety, hassles and hurry, constant noise, crowding, and demands on our time, somehow, most people turn out okay. People may fail to become happy, he says, but few fall to pieces. Considering modern stress, most of us are in surprisingly good condition.

The Promise of Positive Psychology

Easterbrook is a student of psychology and accounts himself well in detailing how Freud's now-discredited ideas led us on a long, wrong path of negativism. Concurrently he applauds the potential of today's "positive psychology movement," whose groundwork was laid by Abraham Maslow in the 1970s.

While the final third of *The Progress Paradox* hammers away at the evidence most people in western society are not happy regardless of their excellent circumstances, Easterbrook never ceases to point out reasons and methods to lift us toward a more optimistic view of life. He leans heavily on the still-strong teachings of Norman Vincent Peale's *Power of Positive Thinking* and its many excellent imitators.

He also has in hand the myriad statistics that show regardless of failed marriages, your chances of health and happiness escalate in marriage as opposed to being single. Likewise he deals well with the literature of forgiveness, whether it be morally or spiritually taught. The psychological proof of the important contribution forgiveness makes to mental health is beyond debate. And he goes further, calling for a little more appreciation and outright thankfulness to those who went before us. He writes,

"Suffering through privation, those who came before us accumulated the knowledge that makes our lives favored; fought the battles that made our lives free; physically built much of what we rely on for our prosperity; and, most important, shaped the ideals of liberty. For all the myriad problems of modern society, we now live in the world our forebears would have wished for us—in many ways, a better place then they dared imagine. For us not to feel grateful is treacherous selfishness.

"Failing to feel grateful to those who came before is such a corrosive notion, it must account at some level for part of our bad feelings about the present. The solution—a rebirth of thankfulness—is in our self interest."

Easterbrook exhibits considerable balance in his absorbing discussions of political philosophy. He states clearly that capitalism is the best thus far, but he hopes for a better system yet to come. Until that day arrives, he writes, "Researching this book, and thinking about the alternatives, has caused me to begin whispering a regular prayer of thanks. Thank you that I and five hundred million others are well-housed, well-supplied, over-fed, free and not content; because we might be starving, wretched, locked under tyranny, and equally not content."

Ever the optimist, Easterbrook concludes his powerful treatise with a detailed history of the Islamic world and why he firmly believes we can defuse the war on terrorism and help the Moslem nations develop the free societies they deserve.

Conclusion

Easterbrook makes a compelling case that optimism, gratitude, and acts of forgiveness not only make modern life more fulfilling but are actually in our self-interest.

This is an important book, easily one of the 10 most important I've read in the past 20 years. Lest any of my readers think I exaggerate and am leading them to a let-down, you should know that the second time I read the book, I liked it even better. Buy this book, read it, and pass it on to a friend. It could actually make a difference.

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PART 2 **IN AN OCCASIONAL SERIES**

Hospitals Face Pressure to Change Pricing Policies

by Conrad F. Meier

Under pressure from Congress and consumer advocates, the hospital industry said it would consider making price adjustments for the uninsured if Medicare officials approve the action. *Health Care News* raised the issue in September 2003 (see "Overcharging the Uninsured"), and the *Wall Street Journal* published a series of articles on hospital policies toward the uninsured last year.

The industry came under scrutiny last year for billing uninsured patients at list prices for lab tests, procedures, and other services, even while it offered steep discounts to patients covered by Medicare, Medicaid, private insurance, HMOs, and negotiated state-run health plans. Randy Suttles, president of Medical Savings Insurance Company, and Merrill Matthews PhD, director of the Council for Affordable Health Insurance, reported in *Health Care News* that hospitals typically charge the uninsured anywhere from 200 to 1,100 percent more than what Medicare beneficiaries or privately insured patients pay.

Thompson Scolds

Tommy Thompson, secretary of Health and Human Services (HHS), told hospitals they can immediately slash the prices they charge to uninsured patients without fear of government reprisal.

In a December 2003 letter, the American Hospital Association (AHA), which represents 4,800 hospitals in the U.S., told HHS federal rules blocked them from cutting prices for the nation's nearly 44 million uninsured. The letter also claimed Medicare policy required "aggressive efforts to collect from all patients," including the uninsured. The AHA asked Thompson to alter or clarify government rules so the industry could help uninsured patients without risking punishment.

Thompson said the hospitals had misrepresented government policy and were simply "not correct" in saying complex federal rules left them no choice but to bill the uninsured full price. He also noted his agency provides hospitals with some $22 billion a year in subsidies to care for the uninsured. In documents accompanying Thompson's response, HHS denied hospitals must use tough tactics to collect payment from the uninsured.

"I strongly encourage you to work with AHA member hospitals to take action to assist the uninsured and underinsured," Thompson wrote to Richard Davidson, AHA's president. The documents, which were hand-delivered to the AHA, represent the federal government's long-awaited answer to the industry's position that federal rules prevent discounted billing or special collection treatment for the uninsured.

Rick Wade, spokesman for AHA, confirmed "there is a lot of clarification" in the Thompson letter, though "there could still be some tripwires." While the documents would help hospitals offer discounts to the indigent, the AHA said, there could be problems offering price cuts to the working poor, who may be significantly over the poverty level but still unable to afford health care. Wade added: "We never intended to blame the federal government. We simply said the regulatory morass was so thick that hospitals couldn't see their way clear to get past that."

Positive Reaction

"This finally puts to rest the hospitals' tired and inaccurate argument that the government made them charge uninsured and underinsured people these crazy inflated prices," said Elisabeth Benjamin, a Legal Aid Society attorney.

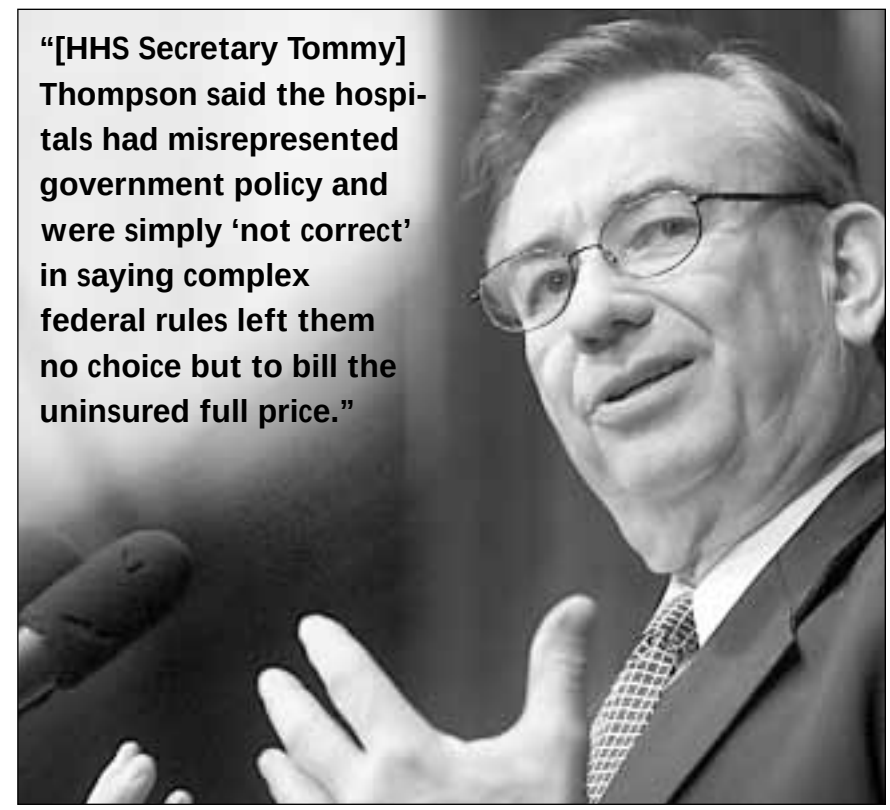
Suttles registered his agreement with the Thompson statement but cautioned hospitals might not respond appropriately. "I strongly support HHS's recently released letter," Suttles said. "But be aware, the hospitals will posture and offer discounts, even 30 percent discounts, off of billed charges. A 30 percent discount off of a 500 percent inflated bill is no deal."

In Suttles' view, "The hospitals should charge reasonable rates to start with. At a minimum, they should charge uninsured and self-pay patients no more than average managed care prices. A practical limit would be Medicare + 20 percent. Medicare pays close to cost. A 20 percent profit on the backs of the self-pay patient should be enough.

"The hospitals can now stop their greed," said Suttles. "HHS says so."

Matthews agreed, telling *Health Care News*, "Everyone knows hospital prices are ruses that bear no relation to the actual cost of providing care.

"The ones most adversely affected by these artificially inflated charges are the uninsured," he continued. "When the uninsured working Americans can't pay four times what those of us with insurance would be charged, the hospitals engage in very aggressive collection practices, collecting, in some cases, 95 percent of the bills. As a result, the uninsured have become huge profit centers for many hospitals."


"[HHS Secretary Tommy] Thompson said the hospitals had misrepresented government policy and were simply 'not correct' in saying complex federal rules left them no choice but to bill the uninsured full price."

KRT

James R. Tallon Jr., president of the United Hospital Fund, a New York think tank, described Thompson's letter as a welcome "template," saying "while there was ample room for criticism of hospitals' behavior, the hospitals were genuinely confused by the thicket of federal regulations." He added the issue of the uninsured had "slipped off people's radar screens," and once it became clear there was a problem, hospitals responded.

"This is one of the classic cases where someone tells the story and lifts up the rock and what was underneath it was a lot of practices and a lot of suffering that were simply indefensible."

Rational Approach to Pricing

Matthews said it is "perfectly fair" for the uninsured to pay for the care they receive ... but it is not fair to make the uninsured a "profit center" for hospitals. Matthews recommended hospitals improve their pricing practices by:

- creating a reasonable and transparent approach to pricing;
- making pricing information available so patients know how much a patient with Medicare, Medicaid, or private health insurance will pay; and
- working with the uninsured to ensure they get a price roughly equivalent to Medicare or managed care.

Tallon says medical bills are now the second leading cause of personal bankruptcy, and "the issue of what hospitals charge for services and what tactics they use to collect unpaid bills has emerged as an increasingly charged political and social issue."

The HHS move, coming in an election year, could help the Bush administration counter Democratic challengers who have argued the President hasn't done enough to help the poor and uninsured.

In addition to its short-term impact on what the uninsured must pay, the HHS action could open the hospital industry's pricing practices to further scrutiny. In recent years, as hospitals have felt squeezed and pinched by managed care, list prices for their services have skyrocketed, so that even simple procedures and short stays can cost thousands of dollars.

A congressional probe, led by the House Subcommittee on Oversight and Investigations, is already underway, examining the rates the nation's 20 top hospital chains charge the uninsured. Labor unions, led by the Service Employees International Union, have organized campaigns in key cities, including New Haven, Connecticut, San Francisco, and Chicago, to highlight pricing disparities that hurt the uninsured.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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LTC Financing Needs Urgent Action

Managing Editor's note: The Bush administration's 2005 fiscal year budget proposal would allow taxpayers—even those who do not itemize—to deduct from their income tax returns any payments for long-term care insurance premiums. The proposal provides an additional personal exemption to home caregivers of family members with long-term illnesses.

Encouraging personal responsibility for long-term care financing, as the Bush proposal does, will become increasingly important as the nation's population ages. According to recent estimates, the U.S. population in 2040 will include more than 12 million people over age 85—more than three times the number who will hit that milestone in 2004. Today, the annual cost for a year of nursing home care varies by region from $51,000 to $65,000. Policy analysts estimate that cost will reach more than $200,000 by 2030.

by Congresswoman Nancy Johnson

Nearly 40 percent of Americans will need some form of long-term care during their lives—but few plan for its cost. Many think Medicare pays for extended long-term care expenses ... but it does not!

We need to help families secure access to the long-term care their loved ones need, not break the backs of our kids to pay for it. If we continue to rely on publicly financed programs like Medicaid to pay for nursing home services, the resulting tax levels—borne by our descendants—will be unsustainable.

We have public (Social Security) and private retirement security programs, and public (Medicare) and privately financed health care insurance. The need to supplement publicly financed long-term care with privately financed options is acute.

Because no one is immune from aging or disability, we all should have some plan to finance a long-term nursing home stay or extended period of home health care. Many of us have had to provide long-term care for an elderly parent or relative and are all too familiar with its costs.

For several years now, I have introduced legislation that would make long-term care insurance more affordable. This measure, endorsed by the AARP, provides tax deductions for purchasing long-term care insurance and tax credits to help offset the cost of providing care to a loved one at home. A tax credit for expenses incurred by care-giving families would help those caring for parents or disabled children at home bear the extra costs.

High Cost of Aging

But the real goal of this bill is to stimulate low-cost policies that young people can buy and let the interest grow over many years. These polices could guarantee three years of nursing home or home care services if they need it—without having to spend down to poverty! Long-term care has the potential to wipe out a senior's retirement savings. As America's population has gotten older, seniors are living longer with multiple, chronic health problems that require more years of expensive long-term care.

Americans spent approximately $33 billion on long-term care in 2000, and costs are estimated to rise five-fold over the next 30 years. The government is currently the predominant payor of long-term care costs, spending more than $75 billion annually. Faced with this demographic tidal wave of aging baby boomers, we must change the way we finance long-term care so that it is fairer and more effective.

Budgets are tight for individuals, too. Currently, average annual long-term care expenses for an individual are about $51,000. How can most American families afford that high cost for even one year? We need to help families plan how to finance the long-term care their loved ones may need. More importantly, we need to allow families to do so without impoverishing themselves to qualify for assistance.

Sadly, if you have a 10-year-old child today, in 20 years when that child is starting a family, buying a house, and depending on a strong economy for a good job to provide an education for their own children, three-quarters of all federal revenues will have to go to fund services for people over 65 years of age. Three-quarters! This places an unbearable tax burden on your 10-year-old child in just 20 years!

Must Get Started

One dramatic change we can make is to shift the $75 billion in tax dollars now spent on long-term care to insurance-based financing. By each taking a modest responsibility—more modest the younger you are—we can lift the burden of the baby boomers' long-term care from the shoulders of our children.

We must get started. Changing the law doesn't change the world overnight, but changing the law now can get these policies moving and foster the development of policies appropriate for young people.

The problems we face today are bigger and more daunting than in earlier eras. The largest retiree population, coupled with the smallest workforce due to the declining birth rate, poses many challenges—and clearly denies us the right to close our eyes to the looming crisis.

Congresswoman Nancy Johnson (R) is serving her 11th term in the House of Representatives. She represents Connecticut's Fifth District and is a member of the House Ways & Means Committee. This article has been edited for space considerations. The full text was originally published in the February 2004 issue of HIU - Health Insurance Underwriter, *a publication of the National Association of Health Underwriters.*

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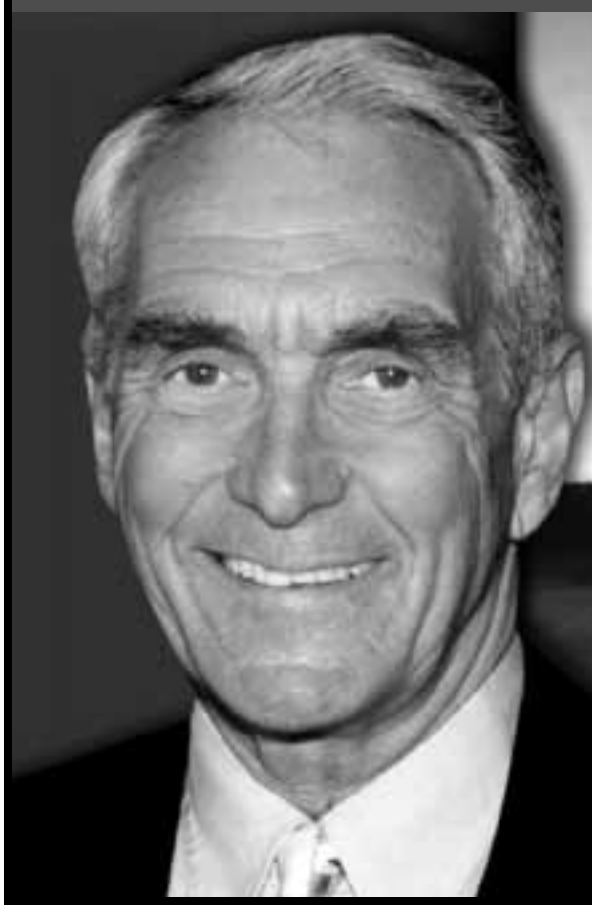

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Consumer-Driven Health Care and the Modern Family

by Greg Scandlen

The way we pay for health care is based on an industrial-age image of the American family that seldom applies today. Women, whether working or not, are especially hurt by this antiquated system.

The underlying assumption of our system is that a man graduates from high school, goes to work at the local plant, and gets his health insurance coverage as a benefit of his job. He marries his high school sweetheart, has kids, works until he's 65, and then retires on Medicare. His wife and family are covered by the policy provided at his job.

If this describes your life, congratulations: Today's health care system is perfect for you.

But if you have ever moved, changed jobs, been unemployed, been divorced, had to pay or receive child support, lived in a two-income family, worked a part-time job, been self-employed, or married an older spouse, you would do better with a consumer-driven health care system.

"[I]f you have ever moved, changed jobs, been unemployed, been divorced, … worked a part-time job, been self-employed, or married an older spouse, you would do better with a consumer-driven health care system."

In a consumer-driven system, individuals would choose their own health insurance program and carry it with them from job to job. Employers may help with the financing of the coverage, but they do not own the policy. Individuals would get the same tax advantage they have when they get coverage at work.

Doesn't Work for All

One example of the problems created by today's system:

A husband and wife both work. The husband's employer pays 75 percent of the cost of his HMO coverage. The wife's employer pays 65 percent of the cost of her PPO coverage. If they both would like to be on the same plan, one or the other will have to forfeit the benefit he or she has earned. If the husband has slightly better benefits, then the wife sacrifices hers—even though she has earned that benefit as surely as she has earned her wages.

In a consumer-driven system, the money your employer spends on health insurance is *your* money, not the company's. If you don't want the company's health plan, you could use those funds to buy your own or pay towards your spouse's coverage.

Another example:

A woman is a stay-at-home mom, five years younger than her husband. Her husband retires at age 65 and goes on Medicare. She loses the coverage her husband had on his job and has to find an individual policy. But she is 60 years old and has no income of her own. Coverage will be very difficult to find—and even more difficult to pay for.

In a consumer-driven system, this would not be a problem. The couple would have owned their own policy instead of being provided one by an employer. The younger wife could keep the same coverage she has always had, but simply drop the husband from the policy once he is covered by Medicare.

A third example:

The husband has a mid-life crisis, quits his job, and runs off to California to find himself. His wife is stuck at home with the kids, but now they are uninsured because they lost their health insurance coverage when the husband left his job. He gets a new job out West, but his employer offers only a local HMO for health insurance coverage. It doesn't have any providers in his old town, so he can't put the kids on his new health plan. To keep them covered he pays the premium for a non-group policy for the children. Now the ex-husband has to pay taxes on the money that goes into the kids' coverage, even though the coverage for them would have been tax-free if they were on his company's health plan.

In a consumer-driven system, the family would have owned their health insurance policy, and the premiums they pay would have been tax-free. They would not have

lost their coverage when the husband took off, and his premium payments would have still been free of taxes.

There are many other examples of how badly the current system serves the modern workforce. The federal government loses more than $120 billion a year in taxes because employer-sponsored health insurance is tax-free compensation. But there is no tax break at all if you buy your own coverage or pay directly for health care services. Federal tax policy forces us all to rely on our employers for coverage. If the employer doesn't come through, we are out of luck.

A consumer-driven system would provide the same tax advantage if we buy our own coverage or pay directly for health care services. We wouldn't have to rely on our employer to fill our needs. That's the system we need in the twenty-first century.

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* **gmscan@aol.com**.

Minnesota

Continued from page 1

But Minnesota Human Services Commissioner Kevin Goodno said, "We're not shutting this Web site down."

Hanging Tough

"We think we're within the law," Goodno said, "and nothing in this letter changes my opinion of that." Acknowledging the FDA could bring civil action against the state, Goodno defended the Web site, saying, "We feel very strongly that we're right, so we have to stand up for what we believe."

Hubbard said that if the state persists in directing Minnesotans to foreign pharmacies, "this is a potential violation of the law." (See "Drug Reimportation Remains Illegal," *Health Care News*, February 2004.)

While FDA officials want to work with the state, they cannot tolerate wholesale defiance of the law. Hubbard told the *Star-Tribune* he could not predict whether legal action would be taken against the state, but he did say the agency is not about to let the state off the hook.

Pawlenty issued a public statement from the National Governors Association meeting in Washington, DC, saying, "Today's communication from the FDA is good news because it is not a legal action designed to shut our state Web site down. We appreciate FDA's critique of our effort but disagree with their conclusions."

Pawlenty went on with his business in Washington, co-hosting a prescription drug meeting with fellow governors Rod Blagojevich (D-Illinois), John Hoeven (R-North Dakota), Jennifer Granholm (D-Michigan), and Jim Doyle (D-Wisconsin). All have expressed interest in linking to Minnesota's Web site. On February 25, Doyle added several Canadian pharmacies to the state's prescription drug savings Web site, www.drugsavings.wi.gov. On February 27, local newspapers were reporting the site received more than 80,000 hits after linking to the Canadian pharmacies.

Pushing the Envelope

Pawlenty said he had been warned the FDA might take action against the state and confessed he was nervous. "I was hoping the FDA would just let us coast along a bit." If a half-dozen states jump on Minnesota's bandwagon, Pawlenty thinks the FDA will support the effort in some fashion.

Pawlenty has been pushing the envelope ever since he advanced the idea for a Web site allowing state residents to buy price-controlled drugs from Canada. His original idea was to also lower the state's drug costs by having state workers fill their prescriptions across the border.

"To encourage the purchase of drugs from Canada is to put a stamp of approval on price controls."

TWILA BRASE, R.N.

When told this would be a deliberate violation of federal law, Pawlenty backed off and instead tried to make the case that Minnesota's Web site should be considered a pilot project.

Twila Brase, R.N., president of Citizens' Council on Health Care in St. Paul, Minnesota, criticized Pawlenty's action. She told *Health Care News*, "To encourage the purchase of drugs from Canada is to put a stamp of approval on price controls. In other words," she said, "the antithesis of free-market policy."

Brase added, "While Governor Pawlenty's idea is politically popular, his administration should put their collective heads together to come up with solutions that don't depend on or endorse the socialization of health care."

Rock and a Hard Place

"The FDA has completely lost all perspective on this issue," complained Peter Wyckoff, executive director of the Minnesota Senior Federation metro region (MSF). About 6,000 MSF members buy Canadian drugs through the federation's Web site program, which has been in operation for more than a year. "I can't imagine the state will close its Web site unless it is ordered to. If that happens, the FDA will be declaring war on efforts to control rising drug costs," Wyckoff said.

"We're sympathetic to their concerns," Hubbard responded. "This is a difficult issue. But there are other ways." For example, Hubbard pointed out, greater efforts could be made to promote the use of approved domestic generic equivalents, which can be even cheaper than name-brand drugs purchased from Canada.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Doctors

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skyrocketing malpractice insurance premiums as the reason.

At United Methodist Village, a Madison County-based residential facility for the elderly, half of the 200 residents recently attended a malpractice insurance forum led by Dr. Leo Green, a retired Alton, Illinois physician.

"Our residents are very concerned," said Patrick Noonan, United Methodist Village administrator. "That's why they came to me to ask if Dr. Green could speak to them. We had a full house with residents from outside the community also in attendance. People are starting to look at this, because our seniors are in need of more attention and care, and their doctors are moving away."

Alton Memorial Hospital has taken out ads in local newspapers and published an information packet on the crisis. The packet includes a list of area doctors willing to address groups concerning the medical malpractice situation, a sample

"More than 30 malpractice insurers have left Illinois or gone bankrupt over the past five years."

letter to send to lawmakers, and lawmaker contact information.

Rob Shelton, Alton Memorial's manager of marketing and development, said 18 physicians—15 percent of the active staff—have left the hospital in the past two years.

"Right now the hospital is okay," Shelton said. "If we lose, in some cases, a single physician, we could be in trouble. If we lose one key surgeon, that would be detrimental to the hospital. We have two anesthesiologists. Losing one would be extremely detrimental."

Shelton also noted that for the first time in more than 20 years, the hospital has no physicians going through the credentialing process.

"We've lost 18 physicians and have no prospects coming in," Shelton said. "Our number one challenge is recruiting. There is no neurosurgeon in our market. Belleville (Memorial Hospital, about 40 miles south in neighboring St. Clair County) has lost its trauma program, and that's directly related to neurosurgery."

System in Turmoil

Metropolitan East St. Louis is by no means the only troubled area of Illinois. Dr. Richard Broderick, a neurosurgeon who practices at three suburban Chicago hospitals, has seen annual malpractice insurance premium increases of 50 percent or more in recent years.

"If they go up another 50 percent, I'm going to have to go somewhere else," Broderick said. "It gets to where, like any business owner, I have to pay bills. I've had to limit my practice to not care for certain high-risk conditions that often have poor outcomes. It's frightening. I tell people all the time there are certain areas where you don't want to get in a

State Sen. Kirk Dillard

car crash, because there is no neurosurgeon in that area."

He said that in Joliet, in suburban Will County, southwest of Chicago, there is no longer a neurosurgeon. The last one lost a large settlement and was bankrupted, he said.

"They took his professional assets and his house," Broderick said. "In Joliet now, they're flying patients to Peoria (nearly 120 miles away) because there are no neurosurgeons. Lawyers are writing letters saying, 'If you don't settle for the policy limits, we will go after you personally and corporately.' It's legalized extortion."

Getting Serious

State Senator Kirk Dillard (R-Westmont) is sympathetic to such complaints. He is lead sponsor of an omnibus tort reform bill backed by the Illinois State Medical Society.

"Our legislature, especially some Democrats for the first time in my memory, is taking the medical malpractice issue seriously," Dillard said. "I believe Democrats in the Metro East area and Republicans throughout Illinois are wishing to pass a meaningful tort reform bill. Generally, this issue is quite partisan, with Democrats stonewalling on behalf of trial lawyers. Now, a couple of the Metro East Democrats are wanting do something, because they're seeing a direct impact on medical care."

Dillard noted that two hospitals near his home—La Grange Memorial Hospital and Hinsdale Hospital—are both owned by Adventist Health Systems and a mere 2 ½ miles apart, yet markedly different in some respects because of the malpractice situation.

"At La Grange they have spent a couple of million dollars improving a birthing center, but you could shoot a cannon off in there and nobody would care because doctors won't deliver there," Dillard said. "At Hinsdale their birthing area is overflowing. La Grange Hospital is in Cook County, where lawsuits are out of control, and Hinsdale Hospital is in DuPage County. That's the difference."

Not that DuPage County is a model of restraint either. One of the Chicago metropolitan counties, DuPage is among 10 Illinois counties from which medical malpractice insurer PIC Wisconsin recently announced plans to withdraw. The others are Cook, Jackson, Kane, Lake, Madison, McHenry, St. Clair, Vermillion, and Will.

PIC Wisconsin's recent announcement follows last year's decision by ISMIE Mutual Insurance Company, the state's largest medical malpractice insurer, to stop writing new business throughout Illinois. ISMIE's moratorium came in the wake of growing underwriting losses and withdrawals by other malpractice insurers. ISMIE wrote 15 percent more policies in 2002 than it had the previous year, as a result of doctors replacing lost coverage. ISMIE officials decided the company could not safely take on more risk.

Democrats in Control

Dr. William Kobler, president of the Illinois State Medical Society, which runs ISMIE, has been stumping the state to generate support for the society's reform bills. He said he's hopeful but realistic.

"Whenever you're talking about anything to do with the legal system, it's an uphill struggle," Kobler said. "I do know that some Democrats [who control both chambers of the General Assembly and the governorship] have started to realize we need to do something about this. But it's one thing to get a bill out of the rules committee and another to get it through the judiciary committee."

In 1975 and 1995, the state legislature passed caps on non-economic damages, only to have them struck down by the state supreme court both times. So the state medical society is not pursuing caps this time.

Instead, the reform bills call for measures to reduce unmerited lawsuits—more than 80 percent of Illinois malpractice suits result in no payments to plaintiffs—and various measures, such as good-faith immunity, to protect doctors from lawsuits and make the state a more attractive place to work.

"We know caps are poison when it comes to the Illinois Supreme Court," Kobler said. "We think our best chance there is with the federal government. We're trying to do things that would be considered more stopgap to keep doctors available. If we can get good-faith immunity for people who see very sick people and who must make very quick decisions in life and death situations, that would be a help. Without that we'll have trauma centers shutting down."

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The Case for Malpractice Reform in Illinois

- **From 1997 through 2002**, the average total jury verdict went up 61 percent.
- **From 1997 through 2002**, the average jury award for non-economic damages has gone up 132 percent.
- **In 1997**, non-economic damages totaled 63 percent of total monetary value awarded by a jury.
- **In 2002**, non-economic damages totaled 92 percent of total monetary value awarded by a jury.

Illinois State Medical Society

Medical Liability Crisis and Access to Care Law

In response to the growing medical liability crisis in Illinois, the state medical society has developed the Medical Liability Crisis and Access to Care Law of 2004. State Senator Kirk Dillard (R-Westmont) is lead sponsor of the measure, which includes the following key provisions:

- Enact good-faith immunity for physicians and other health professionals who provide emergency department or trauma center care.
- Expand free clinic good-faith immunity for health care professionals so that it applies to volunteers in federally qualified health care centers.
- Amend current law to expand the state grant program that awards money for professional liability premiums to apply to all physicians statewide.
- Require the Medicaid payment rate for all physicians to be increased to equal the Medicare rates over a three-year period.
- Prohibit any more than one 90-day extension for the filing of a certificate of merit.
- Increase the minimum qualifications for physicians supplying a consulting report, so that they must meet the same qualifications as expert witnesses.
- Provide immunity for a physician's or health professional's statements or communications of apology for inadequate or unanticipated treatment or care outcomes. A doctor who says "I'm sorry" should not have that expression of sympathy used against him/her.
- Limit voluntary dismissals and prohibit the re-filing of lawsuits after voluntary dismissal, if beyond statute of limitations.
- Require that qualifications for expert witnesses in malpractice litigation be increased so that any expert witness is board-certified or board-eligible in the same medical specialty as the defendant; is familiar with the medical issues alleged in the lawsuit; has devoted 75 percent of his or her time to the practice of medicine, teaching, or university-based research in relation to the medical care and type of treatment at issue; and, if retired, must provide proof of completion of continuing education courses for three years previous to giving testimony.

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TennCare

Continued from page 1

Bredesen aims to keep TennCare spending at roughly one-quarter of the state budget over the next five years. Without the benefit limits and copayments, program spending was expected to reach 36 percent of the state budget in 2008.

Bredesen would exempt from the cost-controlling measures 859,000 children, pregnant women, and people who are disabled, a category that includes people with HIV/AIDS and some with mental illness. Fifteen percent of TennCare enrollees currently represent about 75 percent of the program's cost.

Cutting Back

Bredesen's proposal will affect about a third of TennCare's current enrollees by limiting doctor visits to 10 a year and requiring copayments that range from $1 to $40. TennCare beneficiaries currently are permitted an unlimited number of doctor visits.

Bredesen also would limit TennCare beneficiaries to six prescriptions a month. On average, according to the Centers for Medicare & Medicaid Services (CMS) TennCare enrollees currently fill 30 prescriptions a month, compared to a national average of 10.5 and an average of just 1.5 in the South as a region.

TennCare's pharmacy program cost $2.3 billion in 2003—more than the state's entire higher education system, on which Tennessee spent $1.9 billion. TennCare paid out more for two drugs—Zocor for cholesterol and Zyprexa for schizophrenia and bipolar disorder—than it spent operating the University of Tennessee-Memphis.

TennCare will no longer pay $5.47 per pill of Zyprexa, but instead will buy a 33-cent generic alternative. Most enrollees would be required to purchase the lowest-cost prescription drugs, although some—particularly those being treated for certain mental illnesses—would be permitted to continue current drug regimens.

TennCare will no longer cover antihistamines, such as prescription Claritin Rx, and gastric-acid reducers, like Nexium, except in rare cases, because effective remedies are available over the counter. Antihistamines and gastric-acid reducers currently represent about 12 percent of TennCare's pharmacy spending, totaling $280 million in state and federal funds.

The TennCare program has had eight directors in 10 years—further evidence of a program out of control.

Devil's in the Details

Bredesen's plan was greeted with enthusiasm by lawmakers weary of the TennCare burden. Senator Rosalind Kurita (D-Clarksville) told the *Nashville Tennessean*, "We have ached for this governor. This is a seasoned, reasoned plan. He touched on everything we need."

While doctors, hospital spokespersons, enrollee advocates, and other TennCare stakeholders said they like what they see on the surface of Bredesen's proposal, they cautioned the devil is in the details. Explained Gordon Bonnyman, a Tennessee Justice Center attorney who has sued the state on behalf of TennCare recipients, "There are details to be worked out about who is going to be protected, what the protections consist of, how will the mechanics of the various safety provisions work."

"[Governor Phil Bredesen's proposal] is expected to … [save] $2.5 billion over four years while continuing to provide services to 1.3 million Tennesseans who are poor, disabled, or otherwise not able to get insurance."

Gov. Phil Bredesen

Dr. Subhi Ali, president of the Tennessee Medical Association, said he looks forward to working toward reform with the administration, but he has some concerns about enrollees paying for their own allergy and heartburn medicines. Even those available over the counter are expensive, Ali said, and that "is going to financially inconvenience the core Medicaid population in TennCare."

Nearly all the changes proposed by Bredesen will require approval from CMS. While negotiations have begun, Bredesen asked enrollee advocates not to slow things in the courts. "I am not your enemy in this," he told legislators.

Bonnyman said he does not plan to slow the process and looks forward to working with the governor. "Lawsuits are things you do when nothing else works, when people are backed in a corner," he told the media.

Five Options

Bredesen, who has a background as a health care executive, was himself the principal author of the TennCare reform proposal. His plan relies on work done by independent consultants McKinsey & Co., which concluded a two-part report by finding the state simply cannot afford TennCare in its existing form.

The consultants estimated TennCare would absorb 90 percent of all state revenue growth between 2003 and 2008, threatening other state government priorities. They projected more than $2 billion could be saved over five years by limiting enrollment and benefits and making other changes.

Bredesen used some of the consultants' recommendations as well as his own ideas to come up with the reform plan. The consultants' options were modeled on 25 specific initiatives under broad categories of benefits, enrollment size, case management, pharmacy, and the structure of managed-care organizations. Among the options they presented (not all of which were incorporated into Bredesen's proposal) :

Evidence-based health care. Benefits would be reduced to levels in states with similar programs, and fewer benefits would be provided to TennCare enrollees not on Medicaid. Providers would be required to standardize care. Managed care organizations would take on more financial risk. Enrollees would be required to use the lowest-cost drugs available. *Projected savings:* $940 million - $1.125 billion.

Tailored TennCare benefits and care. Benefits would vary based on need. The uninsured would get the state employees health insurance plan. Most enrollees would share more of the cost, and enrollees in rural areas would be required to pay for their care on a fee-for-service basis. Drug prescriptions would be restricted. *Projected savings:* $680 million - $815 million.

Predictable growth. The state's ability to predict and control growth would be improved by adjusting coverage and enrollment periodically. Benefits would be reduced to levels in states with similar programs, and benefits could change from year to year. *Projected savings:* $945 million - $1.135 billion.

Shared financial responsibility. The state, beneficiaries, and employers would share program costs. Benefits would be reduced to levels in states with similar programs. A "play or pay" mandate would be adopted requiring medium and large employers to offer insurance. *Projected savings:* $930 million - $1.045 billion.

Improved traditional Medicaid. This option would restrict enrollment to the Medicaid-eligible, removing 260,000 people from the rolls. Benefits would be reduced to levels in states with similar programs. Insurance companies would be required to cover applicants with pre-existing medical conditions, instead of reviving the state's high-risk insurance pool. *Projected savings:* $810 million - $945 million.

Left alone, Bredesen warned, TennCare will drain the state's resources for other services and require a return to traditional fee-for-service coverage in the near future. The governor said his plan is "TennCare's last chance," adding, "I want to save TennCare, not dismantle it."

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MY **TURN**

Conrad Meier

The Silent Health Care Epidemic

A silent epidemic threatens the health of millions of people living in the United States; has no regard for age, race, education, or income level; is estimated to cost billions of dollars a year; is immune to preventative care and can't be detected with a physical exam, blood test, or any high-tech diagnostic procedures.

According to physicians, volunteer health associations, universities, and health care companies, the epidemic is health care illiteracy. Forty million U.S. residents are reading at or below the fourth-grade level, with another 50 million residents reading at the eighth-grade level or lower. It is estimated by the National Work Group on Literacy and Health that approximately 66 percent of adults age 65 and older have low health literacy skills. These are the very people who use medical care the most.

Not a New Issue

In 1995, the Joint Committee on National Health Education Standards first used the term "health literacy"—the capacity of an individual to read, interpret, and understand basic health information and services. This includes the ability to comprehend instructions on prescription drug bottles, appointment slips, medical education brochures, and doctor's directions and consent forms, and the ability to properly complete forms for government programs like Medicare and Medicaid.

In general, medical professionals agree health illiteracy is a risk factor for poor health outcomes. Without literacy skills, an individual may find it difficult to manage personal health, which often results in disease complications and health traumas.

Research suggests that people with low health literacy skills:

- Make more medication errors.
- Are less able to follow treatment directions.
- Do not understand medical forms and procedures.
- Are at a higher risk for hospitalization than people with adequate literacy skills.

The costs associated with low health literacy were calculated at more than $73 billion in a 1998 study by the National Academy on an Aging Society. The Centers for Medicare and Medicaid Services estimates Medicare pays out about $10 billion in additional medical care costs related to poor literacy skills. This does not include additional out-of-pocket costs, estimated at $11 billion, incurred by patients.

Barriers

Medical information is becoming increasingly complex and, all too frequently, physicians do not explain things in layperson's terms—or at least at the reading and comprehension level their patients can function at. Physicians are under increasing time pressure in clinical settings and, even more important, they may not know when patients do not understand medical information or instructions.

Many patients, because they are embarrassed or intimidated by the powerful dynamic of the medical experience, do not ask health care providers to explain difficult or complicated information. If patients do not understand medication and self-care instructions, a crucial part of quality medical care is missing. All too often, adverse medical events are described as medical errors, when they really were failures in communication.

Health care illiteracy also can be attributed to the increasing failure of the U.S. education system to teach reading and comprehension skills. (See, for example, "NAEP Reading Scores Tell a Grim Tale," *School Reform News*, June 2001.)

Call to Action

Clear communication should be considered the foundation of our health care delivery system, affecting everything from prevention and screening, to history-taking and explaining diagnosis and treatment. Tools and interventions to improve understanding of health information for all patients must be integrated into written and oral communications between caregivers and patients.

The Joint Commission on Accreditation of Healthcare Organizations suggests information for patient use should be written at fifth- to eighth-grade reading levels. The National Work Group on Literacy and Health recommends a fifth-grade reading level. The American Academy of Family Physicians' Health Education Program recommends a seventh-grade or lower reading level. The University of Utah's Health Sciences Center points out that the average adult typically reads one to two grade levels below their last grade completed.

Until modern medicine finds a way to increase the reading and comprehension level of some senior citizens—and poorly educated adults of any age, for that matter—it must find a way to communicate at the literacy level of patients.

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